PRINTED: 01/03/2013 FORM APPROVED OMB NO. 0938-0391

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY						
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	NC	00	COMPL	ETED		
		15G622	A. BUILDII B. WING	NU		11/29/	2012		
		1		TREET A	DDRESS, CITY, STATE, ZIP CODE	<u> </u>			
NAME OF F	ROVIDER OR SUPPLIE	3	7520 KILMER LN						
COMMUI	NITY ALTERNATIV	'ES-ADEPT			APOLIS, IN 46256				
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	I	D	PROVIDER'S PLAN OF CORRECTION		(X5)		
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	PRI	EFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE.	COMPLETION		
TAG	REGULATORY OF	LSC IDENTIFYING INFORMATION)	Т	AG	DEFICIENCY)		DATE		
W0000									
			W0000	0					
	This visit was fo	or investigation of							
	complaint #IN00	0118998.							
	_								
	Complaint #IN0	0118998: Substantiated,							
	•	e deficiencies related to							
		re cited at W149, W153							
	_	ie cited at w 149, w 133							
	and W183.								
	Dates of Survey	: November 28 and 29,							
	2012.								
	Facility Number	:: 0001159							
	Provider Number								
	AIMS Number:								
	Alvis Nullibel.	100243090							
	,	1. p py p 11.							
		dia Ramirez, RN, Public							
	Nurse Surveyor	III/QMRP							
	These deficience	ies also reflect state							
	findings in acco	rdance with 460 IAC 9.							
	_	mpleted 12/5/12 by Ruth							
	Shackelford, Medic								
	,	-							

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any defiency statement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

7NBE11

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING 00			(X3) DATE SURVEY COMPLETED		
		15G622	B. WIN			11/29/20	012
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 7520 KILMER LN INDIANAPOLIS, IN 46256				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE ((X5) COMPLETION DATE
TAG W0149	483.420(d)(1) STAFF TREATMI The facility must of written policies are mistreatment, negonal and process and proces	ENT OF CLIENTS develop and implement and procedures that prohibit glect or abuse of the client. review and interview for ureau of Developmental ices) reports, the facility lement the facility's dure and neglected to out inadequate for 5 clients living in the ents A, B, C, D and E). : 1:27 AM the facility's and investigations were 9/01/12 through 11/27/12 BDDS report for clients which contained the	Wo		W 149 CORRECTION: The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abus the client. Specifically, the dire support employee who failed to report immediately that he discovered two co-workers sleeping is currently suspended Prior to returning to work, the employee will receive written corrective action and retraining regarding reporting expectation PREVENTION: All facility professional staff will receive to provided with clear expectation regarding reporting, follow-up all required incidents. Facility will be retrained regarding age reporting procedures, with emphasis on timely completion Retraining will focus on the neato immediately report all observor suspected violations regardless of perceived level of severity. Staff will receive a cleunderstanding of the agency's organizational chart to facilitate reporting if the immediate supervisor is not available. The Quality Assurance and Operations Teams will monito compliance with reporting timelines and coordinate	de of ect to ed. gons. be ons for staff ency n. eed rved of ear stee eer	12/29/2012
	_	re asleep. Consumers did			corrective measures as neede RESPONSIBLE PARTIES:	ed.	

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Event ID: 7NBE11

Facility ID: 001159

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPL	
		15G622	B. WIN			11/29/	2012
(F. 6F. F.			-	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER	<u>t</u>		7520 KI	LMER LN		
COMMUI	NITY ALTERNATIV	ES-ADEPT		INDIAN	APOLIS, IN 46256		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	E	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	ļ	DATE
	not suffer any ac	lverse emotional or			QDDPD, Team Leader, Suppo		
	physical reaction to the event and all				Associates, Operations Team, Quality Assurance Team		
	consumers Healthcare Representative				Quality Assurance Team		
	(sic) were notified	ed. Plan to Resolve:					
	[name], OMRP (Qualified Mental					
		essional), will train all					
		g incidents in a timely					
	·	as suspended pending					
	investigation."	as suspended pending					
	investigation.						
	The investigation	n related to the 10/27/12					
	_	iewed on 11/28/12 at					
		ndicated the following:					
		Incident allegedly					
		- ·					
		day, 10/27/12, 4:00 PM.					
		ncident reported to					
		el: Monday, 10/29/12,					
		on reporting incident:					
		and Time Investigator					
	_	10/29/12, 11:40 AM.					
	Nature of Allega	tion/Information					
	provided at time	of Investigator					
	assignment: [Sta	aff #1] reported to [name]					
	RM (Residential	Manager) and [name]					
	QMRP that when	n he reported to work at					
		me on Saturday,					
		PM, he observed [staff					
		asleep in the living					
		staff were on duty in the					
		Conclusion8. The					
		ntiates that [staff #1]					
	_	mmediately allegations of					
	neglect on Satur	-					
	10/27/12Recor	mmendations: 1. Term					

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Event ID: 7NBE11

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MU A. BUII		NSTRUCTION 00	(X3) DATE COMPL	ETED	
		15G622	B. WIN	G		11/29/	2012
NAME OF I	PROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP CODE LMER LN		
COMMU	NITY ALTERNATIV	ES-ADEPT		INDIAN	APOLIS, IN 46256		
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	ATE	(X5) COMPLETION DATE
	(terminate) [staff Term [staff #3] f Retraining and w for [staff #1] for immediately alled On 11/28/12 at 2 facility's 09/14/0 Neglect, Exploit employees active and safety of all allegations or oc neglect and exploit the the appropriatemployees will be reporting and pread exploitation. The insuspected abuse exploitationIna On 11/28/12 at 1 with the Operation of the Superced abuse exploitation of the supervisor clients were unsunknown period indicated staff #2 terminated.	G#2] for sleeping; 2. For sleeping3. Fritten correction action failure to report gation of neglect". 1:50 PM, a review of the 7 Policy on "Abuse, ation" indicated, "Adept ely advocate for the rights individuals. All currences of abuse, bitation shall be reported the authoritiesAll be trained on detection, evention of abuse, neglectand will be trained on dents that are reportable incident types are: In neglect or idequate staff support". 2:01 PM an interview ons Manager (OM) was OM indicated staff failed icy/procedure as they he incident immediately //administrator and the					

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	TOF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA OF CORRECTION IDENTIFICATION NUMBER: 15G622	(X2) MULTIPLE CO A. BUILDING B. WING	00	COM	TE SURVEY MPLETED 29/2012			
	PROVIDER OR SUPPLIER NITY ALTERNATIVES-ADEPT	STREET ADDRESS, CITY, STATE, ZIP CODE 7520 KILMER LN INDIANAPOLIS, IN 46256						
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AF DEFICIENCY)	OULD BE	(X5) COMPLETION DATE			
	#IN00118998.							
	9-3-2(a)							

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Event ID: 7NBE11

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MUL	TIPLE CO	NSTRUCTION	(X3) DATE		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	ING	00	COMPL	
		15G622	B. WING	_		11/29/	2012
NAME OF P	DOMNED OF CLIDAL IED		$\overline{}$	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER			7520 KI	LMER LN		
	NITY ALTERNATIV	ES-ADEPT		INDIAN	APOLIS, IN 46256		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	``	CY MUST BE PRECEDED BY FULL		REFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
W0153	483.420(d)(2)	ENT OF CLIENTS					
		ensure that all allegations					
		neglect or abuse, as well as					
		vn source, are reported					
		e administrator or to other					
	officials in accordance with State law through established procedures.						
			11/01/	.,			12/20/2012
			W015) 5	CORRECTION: The facility me	ust	12/29/2012
		review and interview for			ensure that all allegations of mistreatment, neglect or abus	۵	
	`	ureau of Developmental			as well as injuries of unknown		
	Disabilities Serv	ices) reports, the facility			source, are reported immediate		
	failed to immediately report inadequate supervision for 5 of 5 clients living in the				to the administrator or to other	-	
					officials in accordance with St	ate	
	group home (clie	ents A, B, C, D and E), in			law through established		
	accordance with	state law.			procedures. Specifically, the		
					direct support employee who failed to report immediately that	at	
	Findings include	·•			he discovered two co-workers		
	i mamaga marara				sleeping is currently suspende		
	On 11/28/12 at 1	1:27 AM the facility's			Prior to returning to work, the		
		and investigations were			employee will receive written		
	_				corrective action and retraining	-	
		9/01/12 through 11/27/12			regarding reporting expectatio PREVENTION: All facility	115.	
		BDDS report for clients			professional staff will receive b	oe .	
		E which contained the			provided with clear expectation		
	following inform	nation:			regarding reporting, follow-up	for	
	10/20/12 =	. 1			all required incidents. Facility		
	*	rt submitted to BDDS for			will be retrained regarding age	ency	
		1 10/27/12 at 4:20 PM.			reporting procedures, with emphasis on timely completion	n	
	•	ated, "Staff reported that			Retraining will focus on the ne		
	at 4:20 pm on 10	0/27/12, up on (sic) his			to immediately report all obser		
	arrival to [name]	Group Home that he			or suspected violations		
	knocked and ran	g door bell several times			regardless of perceived level of		
	and received no	answer. After several			severity. Staff will receive a cle		
	attempts, [client	B] (Individual Supported			understanding of the agency's organizational chart to facilitat		
		wered the door. After			reporting if the immediate	C	
		se it appeared that the two			supervisor is not available. Th	е	
		of it appeared that the two	ı		· ·		I

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPL	
		15G622	B. WIN	G		11/29/	2012
NAME OF P	PROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP CODE		
					LMER LN		
COMMUI	NITY ALTERNATIV	ES-ADEPT		INDIAN	APOLIS, IN 46256		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	+	TAG	Quality Assurance and		DATE
	staff on duty were asleep. Consumers did not suffer any adverse emotional or				Operations Teams will monitor	,	
					compliance with reporting		
		to the event and all			timelines and coordinate		
		heare Representative			corrective measures as neede	d.	
	` '	ed. Plan to Resolve:			RESPONSIBLE PARTIES: QDDPD, Team Leader, Suppo	ort	
	2	Qualified Mental			Associates, Operations Team,		
		essional), will train all			Quality Assurance Team		
	·	g incidents in a timely					
		as suspended pending					
	investigation."						
	The investigation	a related to the 10/27/12					
		n related to the 10/27/12 iewed on 11/28/12 at					
		ndicated the following:					
		Incident allegedly					
		day, 10/27/12, 4:00 PM.					
		ncident reported to					
		l: Monday, 10/29/12,					
		on reporting incident:					
		and Time Investigator					
		10/29/12, 11:40 AM.					
	_	tion/Information					
	provided at time	•					
	-	aff #1] reported to [name]					
	`	Manager) and [name]					
	-	n he reported to work at					
	[name] group ho						
	•	PM, he observed [staff					
		asleep in the living					
		staff were on duty in the					
		Conclusion8. The					
		ntiates that [staff #1]					
	_	mmediately allegations of					
	neglect on Sature	day,					

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G622		A. BUILDING B. WING	COMPLETED 11/29/2012					
	PROVIDER OR SUPPLIER NITY ALTERNATIVES-ADEPT	STREET ADDRESS, CITY, STATE, ZIP CODE 7520 KILMER LN INDIANAPOLIS, IN 46256						
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE				
	10/27/12Recommendations: 1. Term [staff #2] for sleeping; 2. Term [staff #3] for sleeping3. Retraining and written correction action for [staff #1] for failure to report immediately allegation of neglect". On 11/28/12 at 12:01 PM an interview with the Operations Manager (OM) was conducted. The OM indicated staff failed to report the incident immediately to the supervisor/administrator and the clients were unsupervised for an unknown period of time. This federal tag relates to complaint #IN00118998. 9-3-2(a)							

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SUR			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPLI	ETED
		15G622	B. WIN			11/29/2	2012
			D. ((11)		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER				LMER LN		
COMMU	NITY ALTERNATIV	ES-ADEPT			APOLIS, IN 46256		
(X4) ID	SUMMARY S	FATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	re	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
TAG W0183	483.430(c)(2) FACILITY STAFF There must be reconduty and awake when clients are proportion appropriate action fire or other emer residential living unit (i) Clients for whordered a medical (ii) Clients who are security risks; (iii) More than 16 (iv) Fewer than abuilding. Based on observation interview for 5 or C, D and E) with facility failed to care staff on duty staff supervision and E. Findings include On 11/28/12 at 1 BDDS (Bureau or Disabilities Servinvestigations we only/01/12 through	FING sponsible direct care staff to a 24-hour basis, present, to take prompt, in case of injury, illness, gency, in each defined unit housing: som a physician has il care plan; are aggressive, assaultive action, record review, and f 5 clients within a multi-unit action, record review, and is behavioral needs, the provide sufficient direct and awake to provide for clients A, B, C, D 1:27 AM the facility's of Developmental ices) reports and the reviewed from in 11/27/12 and indicated for clients A, B, C, D and indicated for clients A, B, C, D and	Wo			ect on a e s on d.	DATE 12/29/2012
	-	t submitted to BDDS for 1 10/27/12 at 4:20 PM.			drop-in visits to the facility at varied times and days -includir weekends, to assure staff are awake and alert. Members of t		

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S COMPL		
AND PLAN	OF CORRECTION	15G622	A. BUI	LDING	00	11/29/	
		130022	B. WIN			11/29/	2012
NAME OF F	PROVIDER OR SUPPLIER						
COMMUI	NITY ALTERNATIV	ES-ADEPT			LMER LN APOLIS, IN 46256		
	SUMMARY S' (EACH DEFICIEN REGULATORY OR The report indica at 4:20 pm on 10 arrival to [name] knocked and ran and received no attempts, [client by [agency]) ans entering the hous staff on duty wer not suffer any ad physical reaction consumers Healt (sic) were notifice [name], QMRP (Retardation Prof staff on reporting manner. Staff w investigation." The investigation incident was revi 11:35 AM and in "Date and Time occurred: Sature Date and Time in facility personne 11:40 AM. Pers [staff #1]. Date as a summer of the control of			7520 KI	ADDRESS, CITY, STATE, ZIP CODE LMER LN APOLIS, IN 46256 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY) Operations and Quality Assurance teams will also conduct unannounced visits to the facility no less than monthl RESPONSIBLE PARTIES: QDDPD, Team Leader, Support Associates, Operations Team, Quality Assurance Team	y. ort	(XS) COMPLETION DATE
	Nature of Allega	tion/Information					
	provided at time assignment: [Sta	of Investigator off #1] reported to [name]					
	RM (Residential	Manager) and [name] n he reported to work at					
	Qiviiki tilat wilei	in the reported to work at					

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MUL	TIPLE CON	ISTRUCTION	(X3) DATE : COMPL		
ANDILAN	OF CORRECTION	15G622	A. BUILD	ING	00	11/29/	
		133022	B. WING			11/29/	2012
NAME OF P	ROVIDER OR SUPPLIEF	8			DDRESS, CITY, STATE, ZIP CODE		
COMMUI	NITY ALTERNATIV	ES-ADEPT			.MER LN APOLIS, IN 46256		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL	PF	REFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		ome on Saturday,					
	· ·	7 PM, he observed [staff					
	#2] and [staff #3] asleep in the living						
		staff were on duty in the					
	home at the time	eConclusion1. The					
		ntiates that [staff #2] and					
		while on duty on Saturday,					
	10/20/12Recoi	mmendations: 1. Term					
	[staff #2] for sle	eping; 2. Term [staff #3]					
	for sleeping3.	Retraining and written					
	correction action	n for [staff #1] for failure					
	to report immed	iately allegation of					
	neglect".						
	Client A's record	d was reviewed on					
	11/28/12 at 12:1	5 PM. Review of the					
	BSP (Behaviora	l Support Plan) dated					
	07/17/12 indicat	ed client A had the					
	following identi	fied behaviors which					
	included, but we	ere not limited to: verbal					
	aggression, delu	sions and physical					
	aggression.						
	Client B's record	l was reviewed on					
	11/28/12 at 12:3	0 PM. Review of the					
	BSP dated 04/06	5/12 indicated client B					
	had the followin	g identified behaviors					
	which included,	but were not limited to:					
	AWOL (absent						
		havior and physical					
	aggression.	* *					
	Client C's record	l was reviewed on					
		5 PM. The record did not					
			I				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G622		(X2) MU A. BUII B. WIN	LDING	NSTRUCTION 00	(X3) DATE COMPL 11/29	ETED		
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 7520 KILMER LN INDIANAPOLIS, IN 46256					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	E RIATE	(X5) COMPLETION DATE	
	Plan). The recon "Behavioral Tradindicated client Cidentified behavioral tracked and limited to: talking cursing and violated of the cursing and cursing and cursing and cursing identification. Client E's record 11/28/12 at 1:15 dated 10/05/12 in following identificated, but we aggression and purchased of the cursing and							

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G622	(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE COMPI 11/29	LETED
NAME OF P	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 7520 KILMER LN			
COMMUNITY ALTERNATIVES-ADEPT			INDIANAPOLIS, IN 46256			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPI DEFICIENCY)	LD BE	(X5) COMPLETION DATE
	#IN00118998.					
	#IN00118998. 9-3-3(a)					

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